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No. 08-45

FILED

AUG 2 1 2008

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SUPREME COURT, U.S.

In The

Supreme Court of the United States

BENEFIT RECOVERY, INC.,

Petitioner,

v.

JAMES J. DONELON, in his Official Capacity as Commissioner of Insurance for the State of Louisiana,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

I. Whether Directive 175, which instructs Louisiana insurers on the mandatory contents of their insurance policies, is a "saved" insurance regulation, *i.e.*, one that alters the scope of permissible bargains between insurers and insureds, when it confers an economic benefit on insureds and could affect the cost of health insurance?

II. Whether the Petitioner preserved for appeal the separate argument that Directive 175 duplicates or supplements ERISA's civil enforcement provision, which argument it failed to raise in the district court?

III. Whether the Fifth Circuit correctly held that the Petitioner could not raise a new argument – that Directive 175 was improperly issued as a matter of *state law* – after the entry of judgment?

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STATEMENT OF THE CASE

The Petitioner, Benefit Recovery, Inc. ("Benefit Recovery"), is a Tennessee corporation. Its business includes, among other things, contracting with health insurers to identify medical expenses potentially subject to the subrogation or reimbursement provisions of insurance policies.[1] Benefit Recovery is not licensed as an insurer in Louisiana, and its activities are not regulated by the Louisiana Commissioner of Insurance (the "Commissioner").

In January 2004, Benefit Recovery contracted with Ochsner Health Plan of Louisiana ("OHP"), a Louisiana corporation. OHP was an HMO and insurer administering group health plans. In the contract, Benefit Recovery agreed to seek to enforce OHP's rights of subrogation or recovery arising out of claims for health-care benefits by insured persons. In return for its services, Benefit Recovery would receive a percentage of the recovery on any such claim.

The record does not reflect whether, and if so when, the Benefit Recovery/OHP contract ceased. Nevertheless, OHP was acquired by Humana Health Benefit Plans of Louisiana, Inc. ("Humana") in 2004.

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[1] As explained below, the parties entered into a written "Joint Stipulations and Designation of Exhibits" as part of their agreement to resolve this matter through cross-motions for summary judgment without a trial on the merits. The statements contained in this section are taken from those stipulations and exhibits.

The record does not reflect whether Benefit Recovery has provided any services to Humana.

In the context of Louisiana insurance regulation, a "directive" is a notice, published by the Commissioner, that communicates the law and policy of Louisiana and instructs insurers of the need to comply with the directive when drafting policies and related documents. In January 2003, the Commissioner promulgated Directive 175 (the "Directive"). The Directive, which was specifically brought to the attention of "all insurers and rate service organizations licensed or doing business in Louisiana," addresses subrogation provisions in insurance policies. Insurance policies should comport with the "make-whole" rule; policy language should clearly convey to insureds that "any right of recovery from third parties on the part of the insurer, whether by subrogation or reimbursement, is subordinate to the insured's right to be fully compensated for his damages. . . ." The Directive further notifies insurers of their obligation to share in the insured's legal expenses in the subrogation context. The Directive addresses the review process for insurance-policy forms and, in order to reduce the need for corrective action, proposes draft language for insurers to consider using.

Directive 175 applies only to insurance policies. It does not apply to self-funded benefit plans under ERISA, or to entities acting as "pure administrators" of such plans. As to insurers, however, the Commissioner has refused to approve the terms of insurance

policies, including policies issued to employer health plans, that did not comply with Directive 175.

OHP's insurance policies in 2001-02 and 2003-04 contained language inconsistent with Directive 175. The Commissioner required OHP to modify the subrogation terms to comply with the Directive. The record does not contain any policy forms used by Humana after its acquisition of OHP.

PROCEDURAL BACKGROUND

A. The parties agreed to have this matter decided on cross-motions without a trial.

Benefit Recovery sued the Commissioner in the Middle District of Louisiana in August 2003.[2] OHP was not a party to the suit, nor was any other Louisiana insurer. Benefit Recovery alleged that it has provided and will provide subrogation services to Louisiana health plans. Challenging Directive 175, Benefit Recovery alleged that enforcement of the Directive "will work irreparable harm on the health benefits providers represented by Plaintiff."[3] Benefit Recovery also alleged that enforcement of the Directive would

[2] In 2003, J. Robert Wooley was the Louisiana Commissioner of Insurance. He was succeeded in 2006 by James J. Donelon.

[3] Original Complaint for Declaratory and Injunctive Relief at ¶ XVIII.

harm insureds by increasing the cost of insurance coverage:

> Continued enforcement of Directive No. 175 will further harm all members of the plans represented by Plaintiff. Health benefits plans like those represented by Plaintiff calculate the premiums charged to members based in part on the amount of money they are likely to receive in subrogation from third-parties primarily responsible for payment of expenses incurred in treating injuries sustained by members through the negligence of the third-party. To the extent that subrogation is eliminated by the application of the Make Whole Doctrine demanded by Directive No. 175, or is curtailed by requiring extensive reimbursement of attorneys in subrogation and reimbursement actions brought by health benefits plans, the cost of health insurance in this state will rise significantly.[4]

Benefit Recovery also alleged that Directive 175 was promulgated without notice and comment; attempted to incorporate doctrines into health-benefit plans in a manner inconsistent with the separation of powers doctrine; and lacked a compelling, substantial, or rational basis. It further alleged that the Directive lacked a jurisprudential basis, violated the Contracts Clause of the Louisiana and United States

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[4] *Id.* at ¶ XIX.

Constitutions, and was completely preempted by ERISA.

The Commissioner initially moved to dismiss Benefit Recovery's complaint on three grounds.

First, the Commissioner argued that Benefit Recovery lacked Article III standing because it has not suffered an injury in fact. The district court disagreed, citing *Lujan v. Defenders of Wildlife*[5] and Benefit Recovery's potential loss of revenue under its contract with OHP.

Second, the Commissioner argued that the court lacked subject-matter jurisdiction because Benefit Recovery was not within the class of persons vested with an ERISA cause of action under 29 U.S.C. § 1132. The district court again disagreed, citing Fifth Circuit authority that a federal court has subject-matter jurisdiction over a suit alleging ERISA pre-emption even though the plaintiff may not have a private right of action under that statute.

And finally, the Commissioner invoked Eleventh Amendment immunity. The district court agreed in part. It recognized that a federal court cannot instruct state officials on how to conform their conduct to state law. Accordingly, it found that the Eleventh Amendment barred Benefit Recovery's claim for declaratory and injunctive relief to the extent based on Louisiana law. Nevertheless, the court stated that

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[5] 504 U.S. 555 (1992).

the Commissioner could be sued, in his official capacity, for prospective injunctive relief to end an alleged violation of federal law. Accordingly, the court held that the Eleventh Amendment did not preclude Benefit Recovery's request for injunctive relief against the enforcement of Directive 175 on the basis of federal law.

The parties later presented their substantive arguments to the court through cross-motions for summary judgment. Contrary to Benefit Recovery's assertions, the district court did not simply dismiss Benefit Recovery's case on a routine Rule 56 motion that addressed less than all of the issues. Instead, and because the few facts that were relevant were not in dispute, the parties *jointly* proposed that the district court decide the case on cross-motions for summary judgment *without a trial*. To that end, Benefit Recovery, along with the Commissioner, represented the following to the district court:

> The parties to this action share a common belief that this action presents only a few discrete issues of law that could be resolved short of adducing testimony at trial. The parties have agreed to reach stipulations of fact and to present the legal issues inherent in this case to the court in either trial memoranda or cross-motion format to be submitted on a schedule to be established by this court.[6]

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[6] Joint Motion to Establish Submission and Briefing Deadlines at ¶ 3.

Benefit Recovery understood that it was incumbent upon it to raise whatever arguments it wished in its motion. It further understood that the motion would take the place of a trial and dispose of the entire case.

B. The district court ruled in favor of the Commissioner after addressing all arguments raised by Benefit Recovery.

The district court agreed with the parties' proposal and signed an order setting a schedule for the filing of dispositive motions or trial memoranda. To facilitate that process, they drafted and filed a set of joint stipulations and submitted a handful of agreed-upon documents.

The Commissioner filed his motion first. He asked the court to dismiss Benefit Recovery's complaint on grounds of prudential standing and, in the alternative, requested summary judgment. As to prudential (not Article III) standing, the Commissioner argued that Directive 175 applies only to Louisiana insurers, not contractors (like Benefit Recovery) that render services to insurers. Since no obstacle exists to a challenge to the Directive by a Louisiana insurer, Benefit Recovery lacked prudential standing. In support of its alternative motion for summary judgment, the Commissioner argued that ERISA did not preempt Directive 175, which is a "saved" insurance regulation that is not applied to self-funded ERISA plans. And finally, the Commissioner

demonstrated that Benefit Recovery's Contracts Clause claim lacked merit.

Benefit Recovery likewise moved for summary judgment. It asserted that the Directive is a "State law" preempted by ERISA. It also argued that the Directive is *not* a "law of any State" for purposes of the saving clause, and further, does not substantially affect the risk-pooling arrangement between insurers and insureds.

The district court granted the Commissioner's motion for summary judgment and issued a 24-page opinion outlining its legal analysis. The court decided that Benefit Recovery had prudential standing to challenge the enforcement of Directive 175. It nevertheless found that the Directive is a "saved" state law, as defined by ERISA, that is specifically directed toward the insurance industry. The Directive substantially affects the risk-pooling arrangement between insurers and insureds. Citing *Kentucky Ass'n of Health Plans, Inc. v. Miller*, the court explained that the Directive "alters the scope of permissible bargains between insurers and insureds."[7] And finally, the court rejected Benefit Recovery's Contracts Clause argument, a claim that the plaintiff did not defend in its motion papers.

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[7] 538 U.S. 329 (2003).

C. After having its case dismissed, Benefit Recovery attempted to raise new arguments through a motion to alter to amend the judgment; the district court denied the motion.

Shortly after the ruling, Benefit Recovery moved the district court to alter or amend its judgment. First, Benefit Recovery raised a new argument and asked the district court to decide whether Directive 175 was valid on state-law grounds – wholly apart from the ERISA-preemption issue. And second, it asked for another opportunity to submit evidence on the saving-clause analysis. The Commissioner opposed the motion.

The district court refused to entertain Benefit Recovery's state-law argument, which was "a new legal argument that cannot be urged under Rule 59(e)." In its motion for summary judgment, the court continued, "Benefit Recovery has relied on a theory of ERISA preemption. Now that this court has ruled against it, the plaintiff attempts to advance a different legal theory."[8]

The court also rejected the plaintiff's assertion that the court somehow refused to let it present evidence bearing on the saving-clause factors. Benefit Recovery's summary judgment memorandum cited *Miller* and argued that Directive 175 did not satisfy its criteria. The court rejected those arguments on the

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[8] Ruling on Plaintiff's Motion to Alter or Amend Judgment, Appendix B to Petition for Writ of Certiorari or Review at 14a.

merits. "Now presented with a ruling against it, the plaintiff argues that it was not permitted to present evidence regarding the *Miller* factors."[9] The court squarely rejected the plaintiff's premise. "It must be remembered that this matter was before the court on Cross-Motions for Summary Judgment. It was the obligation of the parties to present competent evidence and to direct the court to evidence in the record supporting their respective positions."[10] The plaintiff's failure to offer "additional evidence to support its position is insufficient to warrant a Rule 59(e) motion."[11]

D. The Fifth Circuit affirmed the district court.

Benefit Recovery appealed these rulings, and the Fifth Circuit affirmed.[12] The Fifth Circuit began its review by recognizing that "[t]he parties proposed the case be decided on cross-motions for summary judgment and filed joint stipulations of fact."[13] In terms of legal analysis, the Fifth Circuit's opinion is divided into three sections. First, the court addressed Benefit Recovery's new argument on appeal that "ERISA's complete preemption provision, 29 U.S.C. § 1132(a)

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[9] *Id.* at 16a.

[10] *Id.* at 16a-17a.

[11] *Id.* at 17a.

[12] 521 F.3d 326.

[13] *Id.* at 328.

("Section 502") preempts Directive 175."[14] The court did not reach the merits of that issue, finding that the argument had been waived:

> Benefit, however, has not preserved that issue for appeal. . . . Benefit's motion for summary judgment makes explicit that the issue is whether Section 514 preempts Directive 175. The question whether Section 502 preempts the Directive is therefore presented for the first time on appeal, so we do not reach the merits of Benefit's claim. Realizing this hurdle, Benefit seeks to invoke our appellate power through a backdoor: In its reply brief, it urges that parties do not expect cross-motions for summary judgment to end their case. Regardless of the legal merits of such an expectation, Benefit has waived our review of the dismissal of the case, because arguments cannot be raised for the first time in a reply brief.[15]

Second, the court made a similar finding with respect to Benefit Recovery's argument that "Directive 175 is invalid as a matter of federal law because it is an improperly issued state regulation purporting to supply a rule of decision for ERISA plans."[16] The Fifth Circuit determined that Benefit Recovery

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[14] *Id.* at 329.

[15] *Id.* (citing *Yohey v. Collins*, 985 F.2d 222, 225 (5th Cir. 1993)).

[16] *Id.*

waived that argument, as well, by failing to include it in its motion for summary judgment:

> We do not reach the merits of the argument, because Benefit raised it only after entry of judgment. Benefit made the argument for the first time in its unsuccessful rule 59(e) motion. . . . Throughout its submissions to the district court, Benefit relied on a theory of ERISA preemption. When the district court found that argument unavailing, Benefit presented the new argument. The district court did not abuse its discretion in refusing to change its judgment in response to Benefit's motion.[17]

And third, the Fifth Circuit addressed the only merits-based issue squarely presented by Benefit Recovery's appeal, namely, whether "ERISA's conflict preemption section, 29 U.S.C. § 1144(a) ("Section 514"), preempts Directive 174."[18] In concluding that the Directive regulates insurance and is thus "saved" from preemption, the Fifth Circuit rejected the artificial distinction between "State laws" and "laws of any State" created by Benefit Recovery:

> Given the similar breadth of the clauses, if statutes and state supreme court decisions are "State laws," it follows that rules, regulations, and anything else having the effect of law are as well. Nor is there a problem with

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[17] *Id.*

[18] *Id.* at 330.

> the exception's swallowing the rule. State laws need only "relate to" insurance to fall within ERISA preemptive scope; only those laws that regulate insurance are saved. We therefore decline to extend the test set forth in *Miller* by effectively adding a new requirement – distinguishing "State laws" from "laws of any State."[19]

Completing the analysis, the Fifth Circuit confirmed the district court's finding that a directive that instructs insurers as to the circumstances under which they may seek reimbursement from their insureds certainly affects "risk pooling" and is not subject to ERISA preemption.[20]

Benefit Recovery's Petition to this Court followed.

REASONS FOR DENYING THE PETITION

Benefit Recovery waived two-thirds of the issues raised in the Petition. Accordingly, and as the Fifth Circuit recognized, this matter presents only one substantive question, *i.e.*, whether Directive 175 is preempted under section 514 of ERISA. Because the Directive clearly is saved from preemption, Benefit Recovery has not demonstrated any compelling reason for the Court to grant its Petition.

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[19] *Id.* at 331.

[20] *Id.*

I. THE FIFTH CIRCUIT PROPERLY HELD THAT BENEFIT RECOVERY FAILED TO PRESERVE FOR APPEAL THE ARGUMENT THAT DIRECTIVE 175 IS PREEMPTED BY SECTION 502 OF ERISA.

A state statute or regulation may conflict with ERISA in one of two ways.[21] First, the law might be preempted as one that "relate[s] to" employee benefit plans.[22] And second, the law might conflict with ERISA's exclusive enforcement scheme. Benefit Recovery's initial argument relies upon an alleged conflict between Directive 175 and ERISA's enforcement provision, section 502(a).[23] Relying heavily on *Aetna Health, Inc. v. Davila*,[24] Benefit Recovery argued for the first time on appeal that Directive 175 impermissibly supplemented available remedies under ERISA. The argument lacks merit, but as a threshold matter, and as the Fifth Circuit recognized, Benefit Recovery did not preserve this issue for appeal.

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[21] *Louisiana Health Service & Indem. Co. v. Rapides Health Care System*, 461 F.3d 529, 533 (5th Cir. 2006), *cert. denied*, 127 S.Ct. 1831 (2007).

[22] *Id.*

[23] 29 U.S.C. § 1132(a).

[24] 542 U.S. 200 (2004).

"A party must press, not merely intimate, an argument, in order to preserve it for appeal."[25] "The raising party must present the issue so that it places the opposing party and the [district] court on notice that a new issue is being raised."[26] "If an argument is not raised to such a degree that the district court has an opportunity to rule on it, [a court] will not address it on appeal.[27] Under this analysis, Benefit Recovery has clearly waived its *Davila*-based preemption argument. As noted, the district court resolved this case – at the parties' request – on cross-motions for summary judgment. At no time in its moving or opposing pleadings did Benefit Recovery ever contend that Directive 175 impermissibly duplicates or supplements ERISA's civil-enforcement scheme. Instead, it argued only that the Directive "relate[s] to" ERISA plans and does not fall within ERISA's saving clause. As noted in *Louisiana Health Service Indemnity Co. v. Rapides Health Care System*,[28] challenges to state laws based on (1) ERISA's civil-enforcement mechanism and (2) the "relate to" analysis are "*separate preemption arguments.*"[29] Because Benefit Recovery may not raise a new argument on appeal, the Fifth

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[25] *Kelly v. Foti*, 77 F.3d 819, 823 (5th Cir. 1996); *see also Keelan v. Majesco Software, Inc.*, 407 F.3d 332, 340 (5th Cir. 2005).

[26] *Kelly*, 77 F.3d at 823 (quoting *Portis v. First National Bank*, 34 F.3d 325, 331 (5th Cir. 1994)).

[27] *FDIC v. Mijalis*, 15 F.3d 1314, 1327 (5th Cir. 1994).

[28] 461 F.3d 529 (5th Cir. 2006).

[29] *Id.* at 533 (emphasis added).

Circuit was right to not consider this new, separate argument based on *Davila*.

Apart from the procedural bar, *Davila* simply has no application to this case. *Davila* confirmed that a "state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore preempted."[30] The Texas statute in question created a cause of action in favor of any person injured by a plan administrator's negligent handling of coverage decisions. A successful plaintiff could recover damages. This Court held that the statute was preempted because ERISA already provided a cause of action for a plan participant to recover wrongfully denied benefits.[31] Because the alleged injuries covered by the Texas statute and ERISA (section 502(a)(1)(B)) were duplicative, the Texas statute was unenforceable.

In *Louisiana Health Service & Indemnity Co.*, the Fifth Circuit addressed a preemption attack on Louisiana's Assignment Statute,[32] which required insurance companies to honor all assignments of claims made by patients in favor of hospitals. Like Benefit Recovery, the plaintiff relied upon *Davila* and

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[30] *Davila*, 542 U.S. at 208 (quoting *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 147 (1985) (internal quotation marks and citation omitted)).

[31] *Id.* at 214.

[32] La. Rev. Stat. Ann. § 40:2010.

conflict preemption. In rejecting that argument, the Court first noted ERISA's silence on the assignability of employee welfare benefits: "it neither prohibits assignments nor mandates recognition of assignments."[33] In contrast, the court noted, the Texas statute at issue in *Davila* was preempted, in large part, "because of the specific enforcement provisions provided by Congress."[34] The Court then emphasized that the Assignment Statute "does not create an additional means to enforce payment of benefits under an ERISA plan."[35] Once again, this contrasted with *Davila*, which created a new duty on the part of HMOs and imposed liability for any damages proximately caused by the breach of that duty.[36]

As is the case with respect to the assignability of welfare benefits, ERISA is silent on the matter of subrogation.[37] Moreover, Directive 175 does not create a new cause of action or "an additional means" of recovering benefits due from a plan. As explained later in more detail, the Directive, in enforcing the make-whole rule, assures full and comprehensive insurance coverage for Louisiana insureds. In the

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[33] *Louisiana Health Service & Indem. Co.*, 461 F.3d at 535-36.

[34] *Id.* at 535.

[35] *Id.*

[36] *Id.* (citing Tex. Civ. Prac. & Rem. Code Ann. § 88.002(a) (Vernon 2004)).

[37] *Waller v. Hormel Foods Corp.*, 120 F.3d 138, 140 (8th Cir. 1997).

absence of the make-whole rule, as Judge Richard Posner has cogently explained, an insured could be required to "pay back the policy benefits with money he has received for another loss caused by the injury that gave rise to the policy claim, as a result of which the insured would have an uncompensated injury."[38] In simple terms, the make-whole rule embodied in Directive 175 regulates the content of insurance policies and protects insureds against uncompensated losses. In the absence of the rule, health insurance is sometimes only a fleeting benefit. Addressing that circumstance is a matter entrusted to Louisiana's insurance regulators. This Court has never held that state laws regulating the content and required benefits of insurance policies conflict with ERISA's enforcement mechanism, whether the law in question was the requirement for equal mental-health coverage in *Metropolitan Life*,[39] the notice-prejudice rule at issue in *UNUM*,[40] or the any willing provider ("AWP") law in *Miller*.[41]

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[38] *Cutting v. Jerome Foods, Inc.*, 993 F.3d 1293, 1298 (7th Cir. 1993).

[39] *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985).

[40] *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999).

[41] *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003).

II. ASSUMING THAT DIRECTIVE 175 RELATES TO EMPLOYEE BENEFIT PLANS, THE FIFTH CIRCUIT CORRECTLY HELD THAT ERISA DOES NOT PREEMPT IT BECAUSE IT REPRESENTS THE STATE REGULATION OF INSURANCE.

In *Miller,* this Court carefully examined ERISA's saving clause in the context of insurance regulation. *Miller* held that Kentucky's AWP law was a saved insurance regulation. The Court broke from an earlier analysis for determining whether a state law regulates insurance and articulated a new test, which asks:

(1) Is the state law specifically directed towards the insurance industry?

(2) Does the state law substantially affect the risk-pooling arrangement between the insurer and the insured?

As discussed below, with respect to Directive 175, the answer is "yes" to both questions.

A. Directive 175 addresses the conduct of Louisiana insurers and regulates the content of policy forms.

The Louisiana Commissioner of Insurance has full authority to regulate insurers and insurance policies.[42] ERISA does not diminish that authority. As

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[42] LA. CONST. art. IV, § 11; La. Rev. Stat. Ann. § 22:2(A)(1).

this Court explained in *FMC Corp. v. Holliday*,[43] there is "a distinction between insurers of plans and the contracts of those insurers, which are subject to direct state regulation, and self-insured employee benefit plans governed by ERISA, which are not. . . ."[44] Benefit Recovery predictably complains about diminished national uniformity, but that is the price of Congress' intention to respect the states' traditional role in the regulation of insurance. As explained in *Metropolitan Life* and again in *UNUM*, "[s]uch disuniformities . . . are the inevitable result of the congressional decision to 'save' local insurance regulation."[45]

Directive 175 applies exclusively to Louisiana insurers. Those insurers, as a matter of state law, must submit their policy forms to the Commissioner of Insurance for approval.[46] The Directive notifies those insurers about the mandatory contents of their insurance policies, and it proposes language for insurers to consider using in their policy forms. The Directive does not apply to any entity other than a Louisiana insurance company. Thus, the Directive is decidedly *not* a law of general application. Indeed, the Commissioner of Insurance lacks authority to issue directives affecting any industry other than the insurance industry. In its complaint, Benefit Recovery

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[43] 498 U.S. 52, 61 (1990).

[44] *Id.*

[45] *Metropolitan Life*, 471 U.S. at 747; *UNUM*, 526 U.S. at 376 n. 6.

[46] *See* La. Rev. Stat. Ann. § 22:621(3).

implicitly acknowledged the point. It sought an injunction prohibiting the enforcement of the Directive "*against any health benefits provider in the State of Louisiana.*"[47]

Benefit Recovery also contends that Directive 175 is not a "law." As the district court noted, this resulted in an internal contradiction in its argument:

> If this court accepts the premise that Directive 175 is not a "state law" and not subject to ERISA's saving[ ] clause, the plaintiff may have won that battle, but it will have lost the war. Arguing that Directive 175 is not a "state law" is a dubious argument that places the plaintiff on unsteady footing and causes a more problematic issue to come to light. The United States Code provides that ERISA's

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[47] Benefit Recovery suggests that the saving clause does not apply because Directive 175 "is directed only at *health* insurers, not insurers as a whole. . . ." Petition at 25-26 (emphasis in original). Benefit Recovery cites no support for its suggestion that only state laws that address insurers "as a whole" fall within the saving clause, and we are aware of none. In fact, the suggestion is directly contrary to *Miller*; *Miller* addressed a law providing that "[a] *health insurer* shall not discriminate against any provider who is located within the geographic coverage area of the *health benefit plan* and who is willing to meet the terms and conditions for participation established by the *health insurer*, including the Kentucky State Medicaid Program and Medicaid partnerships." *Miller*, 538 U.S. at 331-32 (emphasis added). Notwithstanding the narrow focus of Kentucky's AWP law, the Court held that the law fell within the saving clause because it was specifically directed toward entities engaged in insurance. *Id.* at 334-35.

> preemptive power applies to "state laws." The term "state law" is defined only once in the ERISA context. *Accordingly, if Directive 175 is not a "state law" for the purpose of ERISA's saving clause; it is also not a "state law" that is subject to ERISA preemption.* This would make Directive 175 immune from ERISA's reach and there would be no need to even conduct a saving clause analysis.[48]

The district court was, of course, correct. ERISA defines the term "State law" to include "all laws, decisions, rules, regulations, or other State action having the effect of law of any State."[49] Benefit Recovery has acknowledged that, if insurers fail to comply with the instructions in the Directive, they "will be subject to sanctions including but not limited to the imposition of such fines as are authorized by law." Whether treated as a "quasi-regulation" – a term used by Judge Sarah Vance of the Eastern District of Louisiana[50] – a written communication or order; or

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[48] Ruling on Cross Motions for Summary Judgment, Appendix C to Petition for Writ of Certiorari or Review at 30a (emphasis added).

[49] 29 U.S.C. § 1144(c)(1).

[50] *Gauthreaux v. USAA Cas. Ins. Co.*, 2001 WL 65573 (E.D. La. Jan. 25, 2001), at *2 (taking judicial notice of Directive No. 18 as a matter of public record and as a governing quasi-regulation). *See also generally* La. Rev. Stat. Ann. § 22:1316(A) ("A person subject to the regulatory authority of this department who fails to comply with any directive issued by the commissioner in connection with a consumer complaint shall be fined an amount not to exceed two hundred and fifty dollars for each occurrence").

some other type of official instrument, it is clear that, at a minimum, a directive is state action that instructs insurers on permitted practices and cautions them about the consequences of non-compliance. Nothing more is needed.

Benefit Recovery argues at length that the term "State law" as used in ERISA's preemption clause (section 514(a)) is different from the phrase "law of any State" for purposes of the saving clause (section 514(b)(2)(A)). Benefit Recovery sees "a fundamental, albeit subtle, distinction" between those references.[51] It argues that what constitutes state law for purposes of the saving clause is far narrower and must reflect actual legislation, and not merely "a regulation issued by a state insurance commissioner. . . ."[52] Benefit Recovery cites no jurisprudential support for its reading of the statute, and its argument conflicts squarely with *UNUM* in two important ways.

First, whereas Benefit Recovery contends that the saving clause applies only to "actual legislation," *UNUM* applied the saving clause to a jurisprudential rule.[53] *UNUM* is fully consistent with the broad language of ERISA, which classifies "decisions, rules, regulations, or other state action having the effect of law" as a "state law."[54]

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[51] Petition at 21.

[52] *Id.*

[53] *UNUM*, 526 U.S. at 366-67.

[54] *Id.* at 367, n. 1.

And second, no basis exists to interpret references to state law in the same statute in dramatically different ways. In a unanimous opinion, the *UNUM* Court expressly noted that ERISA's two references to state law were equally broad:

> The preemption clause [of ERISA], § 514(a), 29 U.S.C. § 1144(a), broadly states that ERISA provisions *"shall supercede . . . State laws"* to the extent that those laws "relate to any employee benefit plan." The saving clause, § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A), *phrased with similar breadth, exempts from preemption "any law of any State which regulates insurance."*[55]

Benefit Recovery *admits* that Directive 175 is a "State law" for purposes of section 514(a).[56] It is, therefore, estopped to dispute that the same Directive is also a state law for purposes of section 514(b)(2)(A).[57] As *UNUM* confirms, a state law is a state law – period.

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[55] *Id.* at 363 (emphasis added).

[56] Benefit Recovery concedes that Directive 175 is a "State law" as defined in ERISA. *See* Petition at 19, citing 29 U.S.C. § 1144(c)(1). "Accordingly, because Directive 175 has the effect of law, there is no need to engage in a 'metaphysical inquiry into the nature of law'" (in the words of the Fifth Circuit) in order to find that Directive 175 falls within the scope of 1144(a)." *Id.*

[57] *Hall v. GE Plastic Pacific PTE Ltd.*, 327 F.3d 391, 397 (5th Cir. 2003) ("'[A] party cannot advance one argument and then, for convenience or gamesmanship after that argument has served its purpose, advance a different and inconsistent argument'"

(Continued on following page)

B. Directive 175 affects the risk-pooling arrangement between insurers and insureds; it alters the scope of permissible bargains in the insurance arena.

The second part of the *Miller* test asks whether the state law in question substantially affects the risk-pooling arrangement between insurers and insureds.[58] A law that "alters the scope of permissible bargains" between insurers and insureds – like Kentucky's AWP law – satisfies this test.[59] More generally, laws and regulations that affect an insurer's costs and, thus, the premiums that the insurer will charge, also affect the risk-pooling arrangement.[60]

Benefit Recovery's complaint virtually concedes the point. It tacitly acknowledges that protecting insureds from reimbursement actions in cases in which the insureds are not made whole confers an additional benefit on insureds and imposes a corresponding cost on insurers. The result, Benefit Recovery predicts, could be increased premiums. Assuming

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(quoting *Hotard v. State Farm Fire & Cas. Co.*, 286 F.3d 814, 818 (5th Cir. 2002))).

[58] *Miller*, 538 U.S. at 338. Prior to *Miller*, under the McCarran-Ferguson analysis, the test asked whether the state law *actually spread the risk*. Now, the test asks only whether the law *affects* the risk-pooling arrangement. *Id.* at 339.

[59] *Id.* at 338-39.

[60] *See Louisiana Health Service & Indem. Co. v. Rapides Health Care System*, 461 F.3d 529 (5th Cir. 2006) (Owen, J., concurring).

that is true, an increased premium for an enhanced benefit ought to surprise no one. As Congress and the courts have recognized, this is a policy decision for Louisiana's insurance regulators to make.[61]

FMC Corp. v. Holliday[62] provides important guidance on the viability of Directive 175. *FMC* addressed a Pennsylvania anti-subrogation law, which an insurer challenged on ERISA-preemption grounds. The context was a reimbursement action filed by a health plan; the health plan was self-funded and thus wholly exempt from state regulation. The plan sought to recoup benefits it paid to an accident victim, but the victim objected, citing a state law that precluded subrogation from a claimant's tort recovery under certain circumstances.[63] This Court held that ERISA preempted the state law – *but only in the context of a self-funded plan*. It recognized that the law would have been fully enforceable in the context of an *insured plan*, because an insured plan remains subject to indirect state regulation:

> *There is no dispute that the Pennsylvania law falls within ERISA's insurance-saving clause*, which provides, "except as provided in [the deemer clause], nothing in this subchapter shall be construed to exempt or relieve

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[61] *E.g., Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (state law that mandated employer-provided coverage for mental health fell within saving clause).

[62] 498 U.S. 52 (1990).

[63] *Id.* at 55 (citing 75 Pa. Cons. Stat. § 1720 (1987)).

> any person from any law of any State which regulates insurance. . . ." *[The Pennsylvania law] directly controls the terms of insurance contracts by invalidating any subrogation provisions they contain. . . .* It does not merely have an impact on the insurance industry; it is aimed at it. . . . *This returns the matter of subrogation to state law.*[64]

This passage from *FMC* applies squarely to our case. Directive 175 is an insurance-specific bulletin advising Louisiana insurers that the Commissioner of Insurance will reject insurance-policy forms that do not comply with the make-whole rule. The parties have stipulated that the Commissioner does not enforce Directive 175 against self-funded plans qualified under ERISA. Under *FMC*, then, the Directive is a "saved" insurance regulation.[65]

Without evidence, Benefit Recovery insists that laws addressing subrogation bear no relation to the risk insured against and thus, by definition, do not

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[64] *Id.* at 60-61 (citations omitted; emphasis added).

[65] The district court properly rejected Benefit Recovery's reliance on *Baxter v. Lynn*, 886 F.2d 182 (8th Cir. 1989). The district court recognized that *Baxter*, a pre-*Miller* case from the Eighth Circuit, held only that an anti-subrogation law does not *transfer* the risk from a policy-holder to his or her insurer. But under *Miller*, the law need not actually transfer the risk so long as it substantially affects the risk-pooling arrangement. That effect is beyond good-faith debate. Moreover, several circuits have rejected the reasoning underlying *Baxter* and ruled that anti-subrogation laws meet the (now-superseded) McCarran-Ferguson test.

substantially affect the risk-pooling arrangement between insurers and insureds. Even under the pre-*Miller* analysis, Benefit Recovery is wrong as a matter of basic economics. Judge Posner of the Seventh Circuit reviewed the basic principles underlying the make-whole rule and recognized that differences in subrogation rules may increase or decrease available insurance coverage:

> [S]ubrogation clauses are a common feature of insurance policies. But the "make whole" issue is not about whether insurance subrogation is in general a good thing, as it doubtless is. A "make whole" rule does not enable the insured to gamble on double recovery, as he would be doing without subrogation. *The rule comes into play only if without it the operation of the subrogation clause would, by making the insured in effect pay back the policy benefits with money he has received for another loss caused by the injury that gave rise to the policy claim, leave him with an uncompensated injury.*
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> * * *
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> *If insurance contracts required the insured to assign any tort claim he might have to the insurer, the price of the insurance would be lower but effective coverage would also be lower.* The insured would recover only the policy limits, and not his full damages, even in the case in which a judgment had been secured against

the tortfeasor, and collected, for those damages.[66]

Judge Posner's observations are difficult to refute, and they expose the error of Benefit Recovery's argument. Directive 175, in calling upon Louisiana insurers to comply with the make-whole rule in their policies, effectively mandates *increased coverage*. It avoids the risk that injured insureds will not be fully compensated for their losses. The Directive thus "alters the scope of permissible bargains" between insurers and insureds and easily satisfies the standard articulated in *Miller*.

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[66] *Cutting v. Jerome Foods, Inc.*, 993 F.2d 1293, 1298 (7th Cir. 1993) (emphasis added). The Fifth Circuit has cited Judge Posner's opinion favorably, specifically for its observations about the economic effect of rejecting the make-whole rule in favor of absolute subrogation or reimbursement rights. *Sunbeam-Oster Co. v. Group Benefits Plan for Salaried and Non-Bargaining Hourly Employees*, 102 F.3d 1368, 1376 n. 23 (5th Cir. 1996) (addressing a self-funded plan). The Eighth Circuit, as well, has recognized that the nature of the subrogation applicable under an insurance policy "affects the level of benefits conferred by the plan. . . ." *Waller v. Hormel Foods Corp.*, 120 F.3d 138, 139-40 (8th Cir. 1997).

III. THE FIFTH CIRCUIT PROPERLY REFUSED TO CONSIDER BENEFIT RECOVERY'S POST-JUDGMENT ATTEMPT TO QUESTION THE VALIDITY OF DIRECTIVE 175 AS "SURROGATE FEDERAL LAW."

Benefit Recovery's final argument is that Directive 175, even if not preempted, is an invalid regulation. In order to get around Eleventh Amendment immunity, Benefit Recovery attempts to re-classify Directive 175 as *surrogate federal law*. The effort is unpersuasive.

Benefit Recovery failed to raise this argument in a timely manner in the district court.[67] As it acknowledged below, Benefit Recovery did not argue in its motion for summary judgment (or in opposition to the Commissioner's motion) that the district court should determine the validity of Directive 175 as surrogate federal law. Its argument in that regard came only after the entry of an adverse judgment, in the context of its Rule 59(e) motion. Benefit Recovery evidently assumed that, once the district court rejected its contention that ERISA should preempt Directive 175, it "should have left open the issue of whether Directive 175, as a matter of federal law, is valid."[68] The

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[67] *Kelly v. Foti*, 77 F.3d 819, 823 (5th Cir. 1996); *Portis v. First National Bank*, 34 F.3d 325, 331 (5th Cir. 1994).

[68] Reply Memorandum in Support of Plaintiff Benefit Recovery, Inc.'s Rule 59(e) Motion to Alter or Amend Judgment at 2.

Fifth Circuit upheld the district court's decision not to consider that untimely argument:

> Throughout its submissions to the district court, Benefit relied on a theory of ERISA preemption. When the district court found that argument unavailing, Benefit presented the new argument. The district court did not abuse its discretion in refusing to change its judgment in response to Benefit's motion.[69]

The Fifth Circuit correctly held that Benefit Recovery has not shown an abuse of discretion. In the event this Court chooses to consider Benefit Recovery's argument on the merits, however, it should reject that argument for two fundamental reasons.

First, Benefit Recovery's insistence that Directive 175 has been transformed into federal law is based upon a misreading of the jurisprudence – principally the *UNUM* case. As Benefit Recovery relates, *UNUM* stated that California's notice-prejudice rule supplied "the relevant rule of decision" in an ERISA action.[70] Benefit Recovery reasons that Directive 175, as well, supplies the relevant rule of decision here. From this, Benefit Recovery leaps to the conclusion that the interpretation and validity of the Directive are federal issues. The logic is flawed. Benefit Recovery has misread *UNUM's* reference to the notice-prejudice rule as providing the rule of decision. This Court was

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[69] 521 F.3d at 329.

[70] *UNUM*, 526 U.S. at 377.

addressing the insurer's contention that the state rule duplicated ERISA's civil enforcement provision.[71] In rejecting that argument, the Court explained that the state rule did not authorize an alternate route to collect welfare benefits. Only one route existed – the federal route – and California's insurance regulation fit within it:

> Ward [the insured] sued under § 502(a)(1)(B) "to recover benefits due . . . under the terms of his plan." The notice-prejudice rule supplied the relevant rule of decision for this § 502(a) suit. *The case therefore does not raise the question whether § 502(a) provides the sole launching ground for an ERISA enforcement action.*[72]

In a later passage, the Court again noted that the insured based his suit on § 502(a)(1)(B) for benefits due and "seeks only the application of *saved state insurance law as a relevant rule of decision in his § 502(a) action.*"[73] Nowhere in the opinion did the *UNUM* Court deem California's notice-prejudice rule to be a matter of federal law.

And second, the Eleventh Amendment divests the federal courts of jurisdiction to instruct state officials on how to conform their conduct to state law.

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[71] *Id.* at 376-77.

[72] *Id.* at 377 (emphasis added).

[73] *Id.* at 377, n. 8 (emphasis added).

In the seminal *Pennhurst* case,[74] this Court held that a federal suit against state officials on the basis of state law contravenes the Eleventh Amendment when the relief sought would have an impact directly on the state itself.[75] The Eleventh Amendment equally bars supplemental state-law claims, even if the requirements of 28 U.S.C. § 1367 are satisfied.[76] Accordingly, if Benefit Recovery had openly asked the district court to determine the validity of Directive 175 under state law, such as by deciding whether the Commissioner had the legal authority to promulgate the Directive, the Eleventh Amendment would have barred its request.

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[74] *Pennhurst State School & Hosp. v. Halderman*, 465 U.S. 89, 106 (1984).

[75] *Id.* at 120.

[76] *Id.*

CONCLUSION

The Petitioner has not established any compelling reasons for this Court to grant the Petition. Therefore, the Respondent respectfully requests that the Petition be denied.

Respectfully submitted,

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